5-2024

An Examination of Police Response to Individuals Suffering with Mental Illness

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An Examination of Police Response to Individuals Suffering with Mental Illness

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A thesis

presented to

the faculty of the Department of Criminal Justice & Criminology

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Masters of Arts in Criminal Justice and Criminology

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by

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May 2024

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Keywords: mental health, policing, CIT

ABSTRACT

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The purpose of this study was to examine police officer response to individuals suffering with mental illness. There had been little prior research that used qualitative methods and explored police officers in rural areas. Several research questions were explored, including stigmatizing beliefs held by police officers toward individuals with mental illness, perceived levels of preparedness, challenges experienced by police officers, improvements officers wish to see implemented, and the impact of Crisis Intervention Teams (CIT) training. This study gathered data through semi-structured interviews with 19 police officers who worked in East Tennessee in order to address the research questions. The results from this study provided an understanding of how both CIT-trained and non-CIT-trained police officers respond to individuals suffering with mental illness in rural areas and what changes they would like to see implemented to improve response.

ACKNOWLEDGEMENTS

I would first like to thank my husband, William, for your constant support, appreciation, and love. You are my number one fan and I would not be where I am today without your encouragement. Thank you for being you. To my parents, sister, and family members, thank you all for your support throughout my many years of education. I appreciate the constant encouragement you have all given me and the reassurance that I am capable of whatever I put my mind to. Despite the distance during my education, you have all been there for me and for that, I am truly grateful. I love and appreciate you all.

I also want to thank the Criminal Justice Department at ETSU. The joy I have experienced completing my studies these past two years is a result of the wonderful people that I have come across in this department. You have all truly made this an unforgettable experience. In particular, I want to thank Dr. Edwards for your constant support throughout my studies and this project. Your quick feedback was greatly appreciated! To my committee members, Dr. Osborne and Dr. Prior, thank you for all your help and encouragement. To Dr. Pealer, it has been an absolute pleasure being your graduate assistant throughout my time in graduate school. I will sincerely miss your infectious laugh! I could not thank the incredible people in the department without thanking Christine. Christine, thank you for all the support and guidance you have given me and everyone else. We would truly all be lost without you and we appreciate you more than you know. To my fellow graduate students, thank you for making this one of the most memorable experiences. You have welcomed me with open arms and truly shown me what Southern hospitality means! There is no better group of people I could have wished for to go through this journey with. I am so incredibly grateful to have you as friends. Lastly, I would like to thank the police officers who dedicated their time and shared their experiences with me.

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Chapter 1. Introduction

Mental illness is prevalent across the United States, with approximately 1 in 5 adults experiencing any mental illness (AMI) and 1 in 20 experiencing serious mental illness (SMI) every year (National Alliance on Mental Illness, "NAMI," 2023). In other words, it was reported that in 2021, almost 58 million adults in the United States experienced AMI, and over 14 million experienced SMI (NAMI, 2023). The most commonly occurring mental illness seen among adults in the United States is anxiety disorders, with 19.1% experiencing this (NAMI, 2023). Major depressive episodes are the second most common mental illness (9.3%), followed by posttraumatic stress disorder (3.6%), bipolar disorder (2.8%), borderline personality disorder (1.4%), obsessive-compulsive disorder (1.2%), and schizophrenia, which has the lowest annual prevalence among adults, with less than one percent of the population experiencing this condition (NAMI, 2023).

Despite the prevalence of mental illness, a gap exists with regards to treatment. In fact, it was reported in 2021 that only 47.2% of adults experiencing AMI received treatment, and 65.4% of adults experiencing SMI received treatment (National Alliance on Mental Illness, 2023; Substance Abuse and Mental Health Services Administration, "SAMHSA," 2022). Such mental health services included telehealth appointments, inpatient and/or outpatient services, and receiving prescription medication (SAMHSA, 2022). For those experiencing AMI, prescription medication was the most commonly used mental health service (36.1%), followed by telehealth services (31.6%), outpatient services (24.2%), and inpatient services (3.1%). For the 14 million adults experiencing SMI in 2021, similar findings emerged. The most commonly used services were prescription medication (53.2%), followed by telehealth appointments (49.7%), and outpatient services (40.5%), with inpatient services being the least commonly used mental health

service (6.9%) (SAMHSA, 2022). Although both AMI and SMI mental health services are similarly used, outpatient and inpatient services are used at a higher rate for those with SMI compared to AMI.

While SAMHSA (2022) reports that 65.4% of adults with SMI received mental health services in 2021, a considerable number of adults did not receive any services. For the 14 million adults experiencing SMI, SAMHSA (2022) reports that over half (51.5%) perceive there to be an unmet need for mental health services. Additionally, among adults experiencing SMI, almost three million people did not receive mental health care in 2020, with the most common reason being that they simply could not afford the cost of mental health care (SAMHSA, 2022). Other reasons for not receiving mental health care included individuals believing that they could handle their illness themselves without needing treatment and not knowing where or who to go to receive mental health services (SAMHSA, 2022). It is clear that mental illness is prevalent across the United States, and millions of adults experience mental illness and severe mental illness, with substantial numbers of individuals not receiving any treatment simply because they are unable to afford it.

The prevalence of mental illness and severe mental illness can be seen across numerous areas of the criminal justice system in the United States. There are two specific areas in which this can be seen, and as will be discussed. First, police officers are often the first responders to calls for service involving those with mental illness. Thus, officers' responses and interactions are crucial in ensuring positive outcomes. Secondly, those experiencing mental illness often wind up in jails and prisons, which causes further issues. Before examining the ways in which mental illness is prevalent in the criminal justice system, it is important to understand what contributed

to the substantial number of people with mental illness (PwMI) in jails and prisons and the dire interactions between these individuals and law enforcement.

A History of Deinstitutionalization

Beginning in the mid-1950s, the issue of mental health on a national level was examined, and the Mental Health Study Act led to the creation of the Joint Commission on Mental Illness and Health, which recommended that people with mental illness be treated in the community (Slate et al., 2013). Similar trends continued into the 1960s, with President John F. Kennedy calling for greater community services and signing into law the 1963 Community Mental Health Centers (CHMC) Act (Slate et al., 2013). Such policy changes seen in the mid-20th century aimed to relocate and divert individuals out of psychiatric hospitals and into the community in order to receive mental health services (Dvoskin et al., 2020; Slate et al., 2013). As a result of the mentioned policy changes, the population of psychiatric hospitals declined substantially. In 1955, the population of individuals at state psychiatric hospitals peaked at 559,000. By 1999, the psychiatric hospital population had declined to 80,000, and has continued to decline in recent years. By 2012, only 35,000 state psychiatric beds were available (Dvoskin et al., 2020; Tartaro et al., 2021a; Wells & Schafer, 2006). However, this movement to divert individuals from psychiatric hospitals to community mental health services resulted in many unintended consequences. Inpatient care was not replaced by outpatient care because funding was not allocated (Dvoskin et al., 2020; Slate et al., 2013). Therefore, as a result of the failure to successfully divert individuals to adequate health services in the community, thousands of individuals suffering from mental illness "flooded the streets" (Slate et al., 2013).

In addition to the call for individuals with mental illness to be treated in the community, psychiatric medications began to develop, which resulted in mental health professionals viewing

people with mental illness as more manageable and believing that they would be able to manage their mental illness themselves with medication (Davis et al., 2012). Furthermore, while people with mental illness were being diverted to the community, statutes regarding involuntary commitment were becoming stricter, making it increasingly difficult for states to provide treatment for people with mental illness against their will (Markowitz, 2006; Slate et al., 2013). Court cases such as *O'Connor v. Donaldson* (1975) and *Lessard v. Schmidt* (1976) changed the legal landscape surrounding civil commitment by limiting state's power and changing how involuntary civil commitment must include a dangerousness standard (Davis et al., 2012; Slate et al., 2013). Following these cases, other states began to revise their civil commitment standards. Lastly, after the passing of civil commitment statutes, laws were passed that made people with mental illness entitled to federal assistance programs, thus shifting the costs considerably from the states to the federal government (Davis et al., 2012; Markowitz, 2006; Slate et al., 2013).

As a result of these policy changes seen in the mid-20th century, those with mental illness were diverted to the community in order to receive mental health services. Many of these individuals became homeless, they were arrested and incarcerated, and they had a greater risk of crime victimization. Thus, jails and prisons began to see a substantial growth in their populations of inmates with mental illness (Dvoskin et al., 2020; Slate et al., 2013; Teplin et al., 2005). It is important to note that many people with mental illness who are arrested are typically charged with minor, non-violent crimes or misdemeanors, such as loitering, shoplifting, trespassing, and disorderly conduct, rather than serious crimes or felonies (Hiday & Burns, 2010; Lamb & Weinberger, 1998; National Alliance on Mental Illness, n.d.) For example, in one study, 27.2% of arrests involving people with mental illness were for felonies, whereas 72.9% were for misdemeanors (Compton et al., 2023). Overall, as a result of deinstitutionalization, adequate

community care was unavailable, encounters between law enforcement and PwMI increased, and jails and prisons began to house a record number of PwMI. This contributed to the prevalence of PwMI in the criminal justice system, as mentioned above, and will now be examined further.

The Prevalence of Mental Illness in the Criminal Justice System

Police officers have frequently been referred to as "gatekeepers of the criminal justice system" and "street corner psychiatrists" due to their unique role as first responders when an individual is experiencing a mental health crisis and how it often falls to police officers to respond instead of medical professionals (Bonfine et al., 2014; Lamb et al., 2002; Teller et al., 2006). It has been reported that between 5 and 15% of all 911 calls are for emergencies surrounding behavioral health, while additional studies report that 7-10% percent of all police encounters involve PwMI (Balfour et al., 2022; Fuller et al., 2016; Slate et al., 2013; Watson & Angell, 2013). Some states have recorded higher percentages of police encounters involving PwMI, with Pennsylvania reporting that 28 percent of calls for service are related to PwMI (Rohrer, 2021).

With police officers acting as first responders and gatekeepers to the criminal justice system when responding to calls for services involving PwMI, fatalities and injuries are often seen. Since 2015, the Washington Post has logged and detailed every incident in which an individual has been killed by the police. As of July 31, 2023, 8,660 fatal police shootings have occurred, with 1,013 having occurred in the past 12 months (The Washington Post, 2023). Furthermore, 21 percent of the 8,660 fatal shootings recorded have involved an individual experiencing a mental illness crisis (The Washington Post, 2023). These numbers can be further emphasized by studies that note that individuals experiencing a mental health crisis are 16 times more likely to be killed by law enforcement compared to those who do not suffer from a mental

illness (Chunghyeon et al., 2021; Wood & Watson, 2017). Such findings highlight that encounters between law enforcement and PwMI occur frequently and can often end fatally.

As will be discussed in more depth later in the following chapter, police officers may not have appropriate options available to them when resolving situations involving PwMI other than taking individuals to jail (Engel & Silver, 2001; Markowitz, 2006; Wood & Watson, 2017). This therefore results in an increase in the number of individuals with mental illness in jails and prisons, which is another area in which the prevalence of mental illness can be seen in the criminal justice system. Every year, more than two million individuals with serious mental illness in the United States are booked into jails (Balfour et al., 2022; NAMI, 2023). In addition to the substantial number of individuals entering the criminal justice system with mental illness every year, jails and prisons hold more individuals with mental illness than state psychiatric hospitals across the United States. James Gilligan (2001) argues that prisons have now become the last mental hospitals in existence.

Those suffering from mental illness make up a substantial proportion of the correctional population. For example, within correctional facilities, the percentage of individuals with a mental illness is five to eight times greater than that of those in the general population who suffer from mental illness (Slate et al., 2013). Furthermore, numerous studies have attempted to record the number of individuals in correctional facilities with mental illnesses. The Bureau of Justice Statistics reports that 41% of all state and federal prisoners have had a history of mental illness, with females in state (69%) and federal (52%) prisons more likely than males in state (41%) and federal (21%) prisons to have had a history of mental illness (Maruschak et al., 2021). In addition, based on studies conducted from 2000 to 2009, The Treatment Advocacy Center (2016) estimates that because of the sustained growth of mental illness observed in the criminal justice

system, 20 percent of individuals in jail and 15 percent of those in state prisons today suffer from serious mental illness. These findings are further emphasized when compared to the numbers of those in state psychiatric hospitals. For example, three to five more individuals suffer from mental illness in jails and prisons in the United States than in state psychiatric hospitals (Slate et al., 2013; Treatment Advocacy Center, 2016). To put this into greater perspective, every county in the United States that has both a county jail and a psychiatric hospital has more individuals with serious mental illness incarcerated than hospitalized (Treatment Advocacy Center, 2016).

It is important to note that correctional facilities may trigger or exacerbate symptoms of mental illness. For example, conditions within correctional facilities can trigger and exacerbate mental illness in individuals, such as unstructured days, stress, and an absence of genuine social contact (Metzner & Fellner, 2010). Additionally, practices within correctional facilities as a way to manage difficult prisoners, such as solitary confinement, can also trigger and exacerbate mental illness. Such practices involve restricted contact with others and restricted mental health services that pose substantial risks to an individual's mental health as they may deteriorate, which can lead to serious consequences such as self-harm and suicide (Haney, 2017; Metzner & Fellner, 2010). Individuals coming into correctional facilities already exhibiting symptoms of mental illness may behave in a way that is viewed as dangerous or unpredictable and that results in disciplinary infractions, including solitary confinement and isolation. Again, such practices result in a severe lack of social contact and restricted mental health care (Metzner & Fellner, 2010). As noted, it is important to understand that prisons and jails can trigger or worsen mental illness in individuals.

Current Study

Previous research that has examined topics such as interactions between law enforcement and PwMI, mental health training among police officers, or stigma that officers may hold, for example, has typically explored such themes through the use of vignettes and surveys and has produced quantitative data (Bahora et al., 2008; Compton et al., 2006; Fiske et al., 2021; Godschalx, 1984; M. S. Morabito et al., 2012a; Ritter et al., 2010; Watson et al., 2004b). Fewer studies have explored such topics using interviews and focus groups and have produced qualitative data (Cohen, 2023; Hanafi et al., 2008). Additionally, much research on such topics has taken place in larger cities or counties across the United States, such as Chicago, Atlanta, Lafayette, and Miami-Dade County, and have focused on a small number of police departments within cities and counties, (Compton et al., 2006; Ellis, 2014; M. Morabito et al., 2013; Wells & Schafer, 2006), with few studies examining such matters in more rural areas (Yang et al., 2018). Therefore, the purpose of the current study is to explore themes surrounding police response and encounters with PwMI in a rural area and to produce qualitative data. In addition, through conducting interviews and producing qualitative data, the current study hopes to contribute to criminal justice research by understanding what changes police officers wish to see in how they respond to and effectively deal with PwMI.

Definition of Terms

Various terms should be defined in order to ensure clarity throughout this study. Firstly, it is important to clarify the definition of mental illness and what is meant by it. In this study, "mental illness" or "people with mental illness" (PwMI) will refer to those with *serious* mental illness. Severe mental illness often encompasses disorders such as major depression with psychotic features, bipolar disorder, schizophrenia, and schizoaffective disorder (Slate et al.,

2013). Additionally, serious mental illness impacts and burdens those experiencing it substantially as a result of serious functional impairment, which can hinder and limit life activities (National Institute of Mental Health, 2023).

Secondly, as will be discussed in future chapters, stigma is a prevalent theme in the discussion of mental illness and how people respond to those experiencing mental illness. Therefore, it is important to define what is meant by stigma. In his work on stigma, Erving Goffman (1963) notes many parts that encompass stigma, but it can be simply defined as the condition of a person who is excluded from society and excluded from full social acceptance. Individuals who are stigmatized have particular attributes that set them apart from other members of society; they are subsequently perceived as being less desirable, and in extreme circumstances, they are viewed as dangerous (Goffman, 1963). Furthermore, stigma involves society reducing an individual from a whole person to someone who is not quite human, undesirable, and tainted. As a result of reducing an individual to someone who is not human, a variety of discrimination is exercised; therefore, discrimination is a consequence of stigma (Goffman, 1963; Markowitz, 2014).

Research Questions

The overall aim of this study is to explore and examine police officers' responses to calls for service involving PwMI and their encounters. Within this overarching aim, policies and procedures, CIT and mental health training, competency and preparedness, disposition choices, stigma, and changes police officers would like to see will be examined. This study will focus on the following research questions:

Table 1

Research Questions

RQ1: Do police officers hold stigmatizing views and attitudes towards PwMI?

RQ1a: Do officers report stigma associated with PwMI?

RQ1b: Do officers report social distance associated with PwMI?

RQ1c: Do officers who have received CIT training differ from those who have not on stigma or social distance?

RQ2: Do police officers feel prepared and competent to handle calls for service involving PwMI?

RQ2a: Do police officers feel prepared to handle calls for service involving PwMI?

RQ2b: Do officers feel trained to distinguish between symptoms of mental illness?

RQ2c: Do officers who have received CIT training differ from those who have not on issues related to preparedness and competency of handling calls involving PwMI?

RQ2d: What challenges do officers face when making decisions on how to respond to a call involving PwMI?

RQ2e: Do officers feel that there are sufficient options available for responding to calls for service involving PwMI?

RQ2f: Are there any barriers that need to be addressed to improve the response to calls for service involving mental illness?

(continued)

Table 1 (Continued)

RQ3:	Do officers who have received CIT training perceive this training as adequate? In what ways is it adequate and in what ways is it not?
	RQ3a: Do officers perceive CIT training to be adequate in improving outcomes?
	RQ3b: Has there been any unintended outcomes associated with implementing CIT training?

Chapter Summary

The aim of this chapter was to provide an overview of mental health in the United States, and the ways in which the prevalence of mental illness in the criminal justice system can be seen. Furthermore, the purpose of the current study was discussed in addition to the theoretical work on stigma as an aspect of labeling theory, which was explored as an explanation for why police officers may respond in certain ways during their encounters with PwMI. The following chapter will explore the literature on the variety of themes within the police response to PwMI. Chapter three will discuss the methodology of the current study, including the ways in which data was collected and analyzed. Chapter four will provide the results of the study, and Chapter five will discuss the findings of the study, its limitations, and any policy implications.

Chapter 2. Literature Review

Introduction

As part of their role as first responders, police officers can spend an ample amount of time responding to calls for service (CFS) involving people with mental illness (PwMI). Studies have found that police officers spend more time responding to calls involving PwMI than they do for calls involving, for example, burglaries, assaults, or traffic accidents (Reuland et al., 2009). Furthermore, studies report that 7-10% of all police encounters involve PwMI (Balfour et al., 2022; Fuller et al., 2016; Slate et al., 2013; Watson & Angell, 2013). When interacting with PwMI, police officers' perceptions and attitudes toward mental illness can potentially impact how they respond. For example, force may be used disproportionately towards those with mental illness compared to those without.

This chapter serves to provide an overview of the literature on police response to individuals with mental illness, including stigma, use of force, and dispositional options. Following this, the chapter will review existing literature surrounding Crisis Intervention Teams (CIT) training as a tool to improve police response on the above-mentioned aspects. In addition, this chapter explores preparedness among police officers and the extent to which they feel prepared and competent to respond to calls for service involving individuals with mental illness, and whether or not mental health training impacts their preparedness. Similarly, the literature surrounding future directions and what changes police officers want to see implemented is addressed. Finally, this chapter highlights gaps in the literature surrounding police response to individuals with mental illness and the purpose of the current study is discussed.

Police Response

Stigma

As discussed previously, stigma can be defined as the condition of a person who is excluded from society and excluded from full social acceptance (Goffman, 1963). As a result of having particular attributes that set them apart from other members of society, individuals are perceived as less desirable, and in extreme circumstances, they are viewed as dangerous, and then discriminated against (Goffman, 1963). Markowitz (2014) notes that mental illness stigma is associated with a number of negative stereotypes such as dangerousness, incompetence, and weakness. Dangerousness and being violent are two of the most prevalent misconceptions about individuals with mental illness (Ruiz & Miller, 2004; Slate et al., 2013; Watson et al., 2004a).

While individuals believe that those with mental illness are violent and dangerous, research has shown that the majority of PwMI are not dangerous or violent (Glied & Frank, 2014; Knoll & Annas, 2015; SAMHSA, 2023). Most individuals that suffer with mental health problems do not commit violent acts of crime, and they are not any more likely to be violent compared to those without mental illness. For example, approximately 3-5% of violent crimes are committed by individuals with serious mental illness, more specifically, mass shootings carried out by individuals with serious mental illness comprise less than 1% of all gun-related homicides (Knoll & Annas, 2015; SAMHSA, 2023). In fact, individuals with mental illness are more likely to be the victims of violent crimes than the perpetrators (Desmarais et al., 2014; Teplin et al., 2005).

Despite research showing that the majority of PwMI are not dangerous or violent, stigma towards PwMI still exists within society. Stigma can therefore be a possible explanation for the prevalence of mental illness in the criminal justice system, specifically how police officers

respond to and interact with PwMI. Before examining the literature on stigma and attitudes that police officers may hold, it is important to review and understand society's attitudes and perceptions toward those with mental illness. By understanding society's attitudes and if they hold such stigmatizing beliefs, it can help understand that police officers, as members of society who deal closely with PwMI, may also hold such views.

Many members of society hold the stigmatizing view that those who experience mental illness are violent and dangerous. For example, in their study, Link et al. (1999) used a nationwide survey to examine society's perceptions of mental illness as well as perceived causes, dangerousness, and social distance. Through the use of vignettes, they described individuals with major depressive disorder, schizophrenia, drug dependence, alcohol dependence, and a troubled person, each in different scenarios. This study found that dangerousness is a central aspect of the stereotype of mental illness, and when presented with symptoms of mental illness, people's fears heighten dramatically. This occurs even when violent behavior is not mentioned. Link et al. (1999) conclude that public fears are not in proportion with reality, and despite efforts to curb stigma, the dangerousness stereotype has endured.

With society holding stigmatizing views towards PwMI, it would be reasonable to expect police officers to hold a more stigmatized view than the general population due to their consistent contact with these individuals. Similarly, police officers' interactions typically involve deviant or illegal behavior, therefore contributing to the stigmatized views that they may hold. Slate et al. (2013) argue that stigma and viewing PwMI as dangerous and violent can cause criminal justice professionals to socially avoid such individuals or interact with them in a way during encounters, which produces dire outcomes. In their study, Watson et al. (2004a) surveyed 382 police officers during 30 in-service training courses in the Chicago metropolitan area. This

study, while finding that police officers viewed individuals with schizophrenia as worthy of help and not responsible for their situation, found that police officers nevertheless viewed people with schizophrenia as more dangerous compared to those for whom there was no information provided on their mental illness. Additionally, police officers felt more anger towards individuals with schizophrenia.

Watson et al. (2004b) hypothesized that police officers' responses would be affected if they had information about an individual's mental illness, but this hypothesis was not supported. However, other significant findings did emerge from this study. For example, for individuals they viewed as dangerous, police officers were less likely to act on the information the individuals provided. Similarly, police officers were less willing to take action on behalf of victims with mental illness. Such findings could indicate that police officers do not find people with mental illness capable or credible, a common stereotype of those with mental illness.

In their study, Ruiz and Miller (2004) also found similar mixed results regarding police officers and their attitudes and perceptions towards PwMI. In this study, 164 police departments in Pennsylvania were surveyed in an attempt to gain an understanding of their policies and procedures for handling calls for service involving PwMI, as well as their personal perceptions of violence and dangerousness towards PwMI. Just under half (43%) agreed that PwMI are dangerous whereas 56% of respondents disagreed that PwMI are dangerous. While more respondents disagreed with the stereotype that PwMI are dangerous, it should not be overlooked that 43% agreed with the view that PwMI are dangerous. Additional findings in this study found that 88% of respondents believed that responding to calls for service involving PwMI is just as dangerous as responding to calls for service for an armed robbery. Furthermore, when asked how they felt when responding to calls for service involving PwMI, 49% of respondents felt

"uneasy," "threatened," and "worried" (Ruiz & Miller, 2004). The use of language such as "threatened" implies that police officers view PwMI as dangerous and something to fear. While the studies mentioned so far have had mixed findings regarding stigmatizing attitudes toward PwMI, the results still highlight that some police officers do hold such attitudes.

It is also important to explore how PwMI view their encounters with the police from their perspective. One study to do so was conducted by Watson and Angell (2013). In this study, stigma was examined from the perspective of PwMI and their interactions with police officers. Watson and Angell (2013) surveyed and interviewed individuals they had recruited from three separate psychiatric rehabilitation programs in Chicago. They wanted to examine the effects of perceived stigma and the relationship between perceived procedural justice and cooperation in encounters. Procedural justice refers to fairness in decision-making and procedures (Donner et al., 2015). Additionally, acting in a procedurally just manner involves being fair and neutral in decision-making and treating individuals with respect (Mazerolle et al., 2013). In policing, specifically, research has found that when the general public view the police to be acting in a procedurally just manner, they are more likely to cooperate with the police and comply with any requests, and view the police as legitimate (Mazerolle et al., 2013). According to the results of their study, Watson and Angell (2013) found that people were more cooperative, better behaved, and showed less resistance when they perceived less stigma from the police officers. As a result, they were treated more fairly.

Stigma, particularly the "dangerousness" stereotype, may contribute to the use of force by police officers when encountering an individual with mental illness. Ruiz and Miller (2004) argue that police officers often approach situations believing that an individual is dangerous rather than with the mindset that they are an individual suffering from an illness. By approaching

scenes in this way, it creates a self-fulfilling prophecy and can have tragic results, such as death. Overall, responding to an individual who is in need or experiencing a mental health crisis while holding such beliefs and having a stigmatizing attitude towards them can contribute to excessive or disproportionate use of force by police towards PwMI.

Use of Force

A report published by the Bureau of Justice Statistics (2022) highlights how often force is used by police. For example, it was estimated in 2020 that approximately 21% (53.8 million) of residents living in the United States experienced contact with police in the previous year. Out of these residents who experienced contact with the police, 1.9% experienced the threat of force or nonfatal use of force (Bureau of Justice Statistics, 2022). Additionally, data has been collected and examined specific types of force used by police. From 2015 to 2022, the Washington Post (2023) collected data on police shootings and observed that there have been 8,088 fatal police shootings with 19% (1,694) of these incidents involving an individual with mental illness.

Current research on the use of force by police officers against people with mental illness indicates that higher levels of force are used at a disproportionate rate. In one study that examined observations of patrol officers and field supervisors of the Indianapolis Police Department (IPD) from 1996 to 1997, it was observed that force was used by police officers on 10.8% of PwMI compared to 7.8% of people without mental illness (Engel & Silver, 2001). In another data set of observations of patrol officers in 60 neighborhoods across three major metropolitan cities (Rochester, New York; St Louis, Missouri; Tampa/St Petersburg, Florida) in 1977, the difference was even greater, with force used on 13.5% of PwMI compared to just 3% of those without mental illness (Engel & Silver, 2001). These findings are comparable to those found by Laniyonu and Goff (2021) who examined 28,648 events across nine police departments

in the United States over a six-year period. Results from this study showed that people with serious mental illness are significantly overrepresented in use-of-force incidents (Laniyonu & Goff, 2021). Individuals with severe mental illness were present in 1.3% to 3.1% of encounters, however, the use of force against PwMI ranged from 8.7% to 26.8% of encounters, therefore highlighting the disproportionate rate in which force is used against PwMI (Laniyonu & Goff, 2021). Laniyonu and Goff (2021) concluded that people with serious mental illness are 12 times more likely to experience use of force in encounters with police officers and 10 times more likely to be injured compared to those without mental illness, and are therefore disproportionately represented in use of force incidents.

Such findings could provide support for the argument, noted previously in this chapter, that police officers' approach calls for service involving PwMI with the belief that an individual is dangerous, therefore leading to a self-fulfilling prophecy in which force is used**.** This argument is further supported by the findings from Yang et al. (2018) who examined calls for service and surveyed 71 police officers in Roanoke County, Virginia. They found that PwMI are disproportionately represented in use of force incidents (20.9%), despite only making up a small portion of calls for service (1.3%). As Yang et al. (2018) argue, the findings on use of force incidents among PwMI are corroborated by the responses given by police officers in the survey. For example, 77.5% of police officers reported feeling afraid, unsafe, and in fear of their own safety when responding to calls involving PwMI.

Dispositions

When responding to calls for service involving someone with a mental illness, police officers must decide whether to arrest individuals or to divert them to mental health services in the community (Lamb et al., 2002; Wells & Schafer, 2006). Some options that are available to

police officers when resolving calls for service involving PwMI include doing nothing, handling the matter informally, arrest, involuntary hospitalization, or civil commitment (Slate et al., 2013). Police officers may not want to arrest individuals and process them through the criminal justice system and would rather take them to a mental health facility; however, while this may be the case, sometimes arrests are necessary as they are the only option available. “Mercy bookings” is a term used to describe this predicament police officers may find themselves in. Police officers may use mercy bookings because they have no other way of getting an individual mental health treatment and no other alternatives that are more appropriate are available (Engel & Silver, 2001; Markowitz, 2006; Wood & Watson, 2017). It is also important to understand that hospitals often have strict criteria when it comes to involuntary hospitalization admissions, and police officers can frequently find themselves waiting at hospitals for hours, often with suspects being released as a result of not meeting the admissions criteria (Green, 1997). Therefore, the availability of mental health services and resources in the community, in addition to admission criteria, can affect how police officers respond to calls for service involving PwMI and how they resolve such calls. Furthermore, it is also important to consider that the seriousness of the offense also impacts how police officers resolve such calls, as a diversion to mental health services may not be appropriate.

Some studies have found that police officers disproportionately arrest those with mental illness compared to those without. Livingston (2016) examined 85 studies with 328,461 cases of encounters involving PwMI and police officers in multiple countries and found that 25% of PwMI have been arrested at some point in their lives. Looking specifically at the United States, Teplin (1984) analyzed 884 police encounters involving 1,798 citizens. The study found that 46.7% of those with mental illness were arrested compared to 27.9% of the suspects that were

deemed not to have a mental illness, even after accounting for offense type (Teplin, 1984). In other words, this study observed that PwMI are almost 20% more likely to be arrested compared to those without mental illness. As discussed above, Teplin (1984) notes that in their study, police officers knew that psychiatric hospitals in the community had strict admission requirements; therefore, they needed another disposition. Further, Teplin (1984) concluded that the requirements that are needed to be admitted to a psychiatric hospital, which are found in many mental health codes, mean that individuals are considered "undesirable" by hospitals, therefore resulting in arrest. While research shows that PwMI are arrested at a higher rate compared to those without mental illness, this is not to say that PwMI are involved in more crime. These findings could very well be a result of a lack of available mental health services in the community that police officers can successfully divert PwMI to.

In a more recent study, Engel and Silver (2001) aimed to build off of Teplin's (1984) study and examined arrest rates from two data sets from two periods in time: the Project on Policing Neighborhoods (1996-1997) and the Police Service Study (1977). Both data sets included data from metropolitan police departments across different U.S. cities. While this study aimed to build from Teplin's (1984) study, it produced conflicting results. Engel and Silver (2001) found from the Project on Policing Neighborhoods data that police officers were significantly less likely to arrest PwMI (7.6%) compared to individuals without mental illness (18.2%). Additionally, from the Police Service Study dataset, results showed that, while PwMI (16.2%) were arrested at a higher rate compared to individuals without (13%), such findings were not statistically significant (Engel & Silver, 2001). Therefore, studies examining arrest rates among PwMI have found conflicting results, with some studies showing PwMI are arrested at

higher rates compared to individuals who do not experience mental illness, whereas other studies have found that PwMI are not arrested at a disproportionate rate.

Other research has examined dispositional options available to police officers in addition to the rate of arrest, as has been examined above. Wells and Schafer (2006) argue that arrest is likely due to limited mental health resources in the community. In their survey of 126 police officers across five departments in Indiana, it was observed that police officers are not satisfied with the disposition options available to them, with 97% of police officers stating it needs to be easier to get PwMI into treatment facilities (Wells & Schafer, 2006). Additionally, 60% of respondents believed that the most appropriate disposition when resolving calls for service involving PwMI is a psychiatric hospital; however, only 38% of officers take PwMI to the hospital. In a similar study, Yang et al. (2018) found that only half (50.7%) of police officers were satisfied with the dispositional options available to them. Furthermore, the top disposition was voluntary hospital transportation by the police department (76.1%).

While the previously mentioned studies have focused on surveying police officers directly, Livingston et al. (2014) interviewed individuals who had been recruited from mental health centers and asked them about their encounters with the police. In this study, results showed that the most common resolution was no action taken (32%), with other dispositions including taking the individuals to the hospital for psychiatric treatment (15%), taking participants to the hospital for medical treatment (12%), and referring them to a mental health agency or service (7%). As has been explored so far, police response encompasses varying aspects, with previous research finding conflicting results in many areas of police response. As will be discussed throughout the rest of the chapter, mental health training can have a substantial impact on police response and encounters with PwMI.

Training to Improve Response

The literature examined thus far has focused primarily on stigma, use of force, and dispositions as part of the police response during encounters with PwMI. In order to improve response, mental health training, particularly Crisis Intervention Team (CIT) training, has been implemented across the United States with varying results. CIT was first developed in Memphis in the 1980s as a response to the fatal police shooting of an individual with mental illness (Balfour et al., 2022; Cochran et al., 2000). Since then, there has been a rapid growth in the number of programs being implemented across the country. It was reported in 2008 that there were 400 programs across the country, with this number growing to over 2,700 in 2019 (Rogers et al., 2019). To effectively respond to individuals suffering from mental illness, CIT requires law enforcement professionals to complete 40 hours of specialized training (Watson et al., 2008). While CIT has developed in many ways since the 1980s and police departments differ in how they implement it, the developers of the program set forth basic goals and aims of the program. Through the use of proper and effective training, the aims of CIT include improving the safety and risk of injury of police officers and those with mental illness, and effectively redirecting individuals from the criminal justice system to mental health facilities and services (Dupont et al., 2007; Dupont & Cochran, 2000; University of Memphis CIT Center, n.d.). Furthermore, Dupont et al. (2007) argue that the goals of CIT include training enough law enforcement professionals so that there is an adequate number trained, therefore having enough officers on duty to respond to calls at all times. CIT training has been further developed by including visits to treatment centers and mental health facilities, role-playing, and hearing personal stories from people with mental illness and their families (Watson et al., 2008). In addition, the goals of CIT have grown to include improving officer knowledge and understanding of the signs and

symptoms of mental illness, decreasing attitudes and stigma towards PwMI, causes of mental illness, reducing unnecessary arrests, and reducing the use of force (Balfour et al., 2022; Slate et al., 2013; Watson et al., 2008). As will be discussed, numerous studies have examined the effectiveness of CIT as a tool to improve police response in their encounters with PwMI.

CIT and Stigma

Research that has examined whether CIT can reduce stigmatizing attitudes among police officers towards PwMI examines stigma by looking at attitudes and perceptions, but also social distance and whether police officers feel frightened or uncomfortable during encounters. With regard to reducing stigma, numerous studies have found CIT to be an effective tool. A survey of police officers in Atlanta before and after CIT training found that following training, police officers reported lower levels of social distance, and their views concerning aggressiveness also improved (Compton et al., 2006). This study also provided support for the argument that CIT can change myths surrounding mental illness and that educational programs can be an effective tool in reducing stigmatizing beliefs towards individuals with schizophrenia (Compton et al., 2006). In a similar study that also examined stigmatizing attitudes on the first and last days of CIT training, Ellis (2014) found a 34.18% change in stigmatizing attitudes and a 39.81% change in perception from police officers after CIT training. Therefore, this study found support for the hypothesis that stigmatizing attitudes and perceptions can improve following CIT training. While studies have shown that CIT has an effect on reducing stigma among police officers, Nick et al. (2022) claimed, however, that CIT does not completely diminish these beliefs. For example, 76.1% of police officer trainees held at least one stigmatizing belief surrounding mental illness before CIT training, and this reduced to 60.9% of trainees following training. Overall, it was recorded that 52.2% of trainees reported fewer stigmatizing attitudes after training.

As discussed previously, stigma can be examined by looking at attitudes and perceptions, as well as social distance and whether police officers feel frightened or uncomfortable during encounters. While some studies have looked at stigma as a whole, others have found results that just focus on stigma that emerges during encounters, such as social distance. For example, a survey of 126 police officers from five police departments in Lafayette, Indiana, found that before training, one-third of officers felt uncomfortable when interacting with PwMI, but this reduced to just under 25% following the completion of CIT training (Wells & Schafer, 2006). The studies mentioned thus far have used pre-test and post-test surveys in order to examine the effect of CIT on stigma. In their study, which examined social distance, Bahora et al. (2008) had a control group of officers who had not received CIT training and used this group to compare with a group of officers before and after they received CIT training. This study found that before CIT, there was no difference in social distance between the officers in the control group and the officers who had not yet completed training. However, following CIT, social distance significantly decreased. Bahora et al. (2008) concluded that a decrease in social distance has important implications as it can result in greater safety in encounters between police officers and PwMI.

While research has found support for CIT as an effective tool to reduce stigma among police officers, other research has found CIT training to not produce significant changes in officer attitudes (Demir et al., 2009; Haigh et al., 2020). While there are inconsistent findings, it is important to note that studies often survey police officers on hypothetical situations. For example, Demir et al. (2009), in their study that examined how attitudes towards schizophrenia change after CIT, concluded that how stigma translates into practical changes seen in the field needs to be examined. Similar sentiments were stated by Nick et al. (2022), who noted that the

extent to which training translates into practice in the field is not known. However, in their study, Hanafi et al. (2008) utilized focus groups in their study on the effectiveness of CIT and as such, they could examine the effectiveness of CIT on stigma in the field. Officers in this study discussed how CIT increased their knowledge, which then reduced stigma. For example, one officer stated how CIT "Helps you see [the consumer] more as a person instead of a problem," with another officer discussing how they have grown past prejudging PwMI (Hanafi et al., 2008). It is clear that findings on the effectiveness of CIT on stigma are mixed, and most studies have utilized surveys on hypothetical situations; therefore, how stigma translates into practical changes in the field is mostly unknown.

CIT and Use of Force

As discussed previously, research that has examined the use of force by police officers against PwMI has found that more serious levels of force are used at a higher rate and that PwMI are disproportionately represented in use-of-force incidents (Engel & Silver, 2001; Laniyonu & Goff, 2021; Yang et al., 2018). Just as has been done with stigma, the effectiveness of CIT to reduce the use of force towards PwMI has also been examined. In their examination of 655 incident reports completed by approximately 200 CIT police officers in Las Vegas, Nevada, Skeem and Bibeau (2008) found that force was only used in 36 (6%) of events. In these 36 events where officers used force, lower levels of force were used, such as hands-on force, compared to higher levels of force, such as a taser or a gunshot with low-lethality. Additionally, it was observed that force was only used in 15% of the 189 incidents with a serious to extreme potential for violence.

When assessing the effectiveness of CIT on the use of force by police officers, studies have used control groups and compared the use of force between police officers who have

received CIT training and police officers who have not. For example, Compton et al. (2011) surveyed 48 CIT officers and 87 non-CIT officers in a police department in the southeastern United States and found that officers who had received CIT training believed it was more effective to use nonphysical actions. Additionally, in the survey, CIT officers selected actions with lower physical force compared to the police officers who had not received CIT training (Compton et al., 2011). In a similar study, Morabito et al. (2012) found that even when an individual becomes increasingly resistant, officers who have received CIT training are less likely to use force in response compared to officers who have not received CIT training.

Unlike the studies mentioned thus far, which have shown CIT to have a positive effect on the use of force, Kerr et al. (2010) found mixed results on the effectiveness of CIT on the use of force. While verbal warnings were used more than other types of force and firearms were not used in any of the 865 incidents recorded, it was observed that CIT did not reduce injuries towards PwMI. In a separate study, Morabito et al. (2017) examined 4,211 cases from the Portland Police Bureau on use of force from 2008 to 2011. It is important to note that a core element of CIT is that only a set number of officers should receive training and that they should voluntarily apply for it (Dupont et al., 2007). However, since 2008, every officer who works for the Portland Police Bureau has received CIT training. Morabito et al. (2017) observed that individuals who did not display behavioral health disorders were less likely to have physical force used against them compared to those displaying comorbid disorders. While it could be argued that CIT did not have an impact on the use of force, Morabito et al. (2017) note that the behaviors of the individuals can also shape the response from the police officers in addition to training.

Additional mixed results regarding the use of force were observed by Compton et al. (2014). It was found that there was no overall difference in the use of force between CIT officers and officers who had not received CIT training. However, there was a difference between the officers at the highest level of force used, which suggested that officers who received CIT training used de-escalation techniques (Compton et al., 2014). While this study found no overall difference in the effectiveness of CIT on use of force, it was observed that when it comes to resolutions and dispositions, CIT officers were more likely to transfer PwMI to mental health facilities and less likely to arrest (Compton et al., 2014).

CIT and Dispositions

Research that has examined CIT and its effect on how police officers resolve encounters focuses greatly on the effectiveness of CIT in reducing arrests. In addition to arrest, research has also studied the impact of CIT on diversions to mental health services and facilities. Studies have found that CIT increases referrals to mental health facilities and that this occurs more than arrests (Compton et al., 2014; Franz & Borum, 2011; Skeem & Bibeau, 2008; Taheri, 2016; Yang et al., 2018). For example, Franz and Borum (2011) examined 1,539 CIT calls from nine law enforcement agencies in Florida and found that the arrest rate for these CIT calls was only 3%. In a similar study that also looked at arrest rates, Taheri (2016) carried out a systematic review of eight studies and observed that officers who had received CIT training were less likely to arrest PwMI compared to officers who had not received the training. As mentioned above, studies have also looked at how effective CIT is at diverting PwMI away from the criminal justice system and toward mental health services. In an examination of 655 After Action Reports (AARs) completed by CIT officers in Las Vegas, Skeem and Bibeau (2008) found that the most common disposition

was hospitalization (74%), with arrest occurring in only 6% of cases. This suggests that CIT can be an effective jail diversion tool.

The above studies have observed data on arrest rates and successful diversions to mental health facilities. However, in their research, Yang et al. (2018) studied police officers' personal views on the effectiveness of CIT in addition to examining calls for service data. Results found the most common disposition when responding to calls for service involving PwMI was voluntary hospital transport by the police department (76.1%), with arrest only occurring in 8.5% of encounters. Furthermore, 76.6% of police officers agreed with the statement that CIT training increases a police officer's likelihood that they will refer individuals to mental health services (Yang et al., 2018).

The studies mentioned thus far have observed positive outcomes as a result of police officers receiving CIT. However, mixed findings have emerged in other studies. In their study, Teller et al. (2006) analyzed calls for service data in Akron, Ohio, two years before implementation of CIT and four years after implementation in order to measure the effectiveness of CIT on police officers' dispositions. From 1998 to 2004, over 1.5 million calls for service were made, with just over 10,000 of these calls relating to mental health disturbances. Teller et al. (2006) found a positive effect of CIT, with CIT officers more likely to take individuals with mental illness to mental health facilities. Similarly, it was observed that after CIT was implemented, the rate at which PwMI were transported to jail decreased. However, this was only a slight decrease from 3% to 2.9%. Additionally, negative findings on the effect of CIT emerged. For example, Teller et al. (2006) found that officers were more likely to transport PwMI to jail (4.1%) versus officers without CIT training (2.4%). Teller et al. (2006) note that the higher rate of arrest was unanticipated, yet it could be explained by the fact that CIT officers have received

training, so they may have a greater understanding compared to non-CIT officers when making an arrest is preferred.

As discussed above, there have been conflicting findings on the effectiveness of CIT and how it can improve stigma, use of force, and dispositional decision-making for police officers. While studies have utilized different research methods, from surveys to focus groups to analyzing records, it is important to note that some studies use hypothetical situations and do not examine the effect of CIT in the field. Therefore, we are unsure how well these results translate into real-life practice. One area that might further the assessment of the effectiveness of CIT and provide a greater understanding of police response to PwMI is preparedness and whether police officers feel confident and adequately prepared to respond to calls for service involving PwMI.

Preparedness

With police officers often responsible for responding to calls for service involving PwMI, it is important to consider whether or not police officers are competent to respond to such incidents (Alpert, 2015). Bittner (1967) argues, for example, that dealing with incidents involving PwMI is incompatible with a police officer's primary role; therefore, they lack training and competence. Bittner's (1967) sentiment is echoed by studies that have assessed how police officers feel when responding to calls for service and how training and other factors impact feelings of preparedness. For example, Clayfield et al. (2011), in their survey of 379 police officers in a police department in the northeastern United States, found that officers who had received mental health training in the past felt more prepared to respond to incidents involving PwMI. Additionally, police officers who had personal experiences with mental illness felt more prepared.

Other studies have examined whether officers who have received CIT training feel prepared compared to non-CIT officers (Bonfine et al., 2014; Borum et al., 1998; Ritter et al., 2010; Tartaro et al., 2021b). For example, Ritter et al. (2010) surveyed both CIT and non-CIT officers and found that before receiving CIT training, officers were more likely to report feelings of unpreparedness. However, following CIT training, they felt more prepared. The change in feelings of preparedness increased from 26% to 97% following training (Ritter et al., 2010). In a similar study, Bonfine et al. (2014) surveyed 57 volunteer CIT officers in Ohio and observed that 93% of officers were very confident in their ability to respond to calls for service involving PwMI. The CIT officers were also surveyed on their views of non-CIT officers, and 89% stated they do not believe non-CIT officers are prepared to handle these types of calls for service (Bonfine et al., 2014). While CIT training has been implemented widely across the United States, not all police officers are required to receive it. Furthermore, those who have received training believe that it is important, but it is not enough, and they want more (Bonfine et al., 2014; Cohen, 2023; Vermette et al., 2005). These are areas that law enforcement professionals and researchers argue need to change in order to improve police response in encounters with PwMI.

Future Directions

One of the core elements of the CIT program is that only select officers should receive training and that they should voluntarily apply for the program (Dupont et al., 2007). Researchers who have assessed the effectiveness of CIT in a variety of ways agree with this core element (Cohen, 2023; Compton et al., 2017; Hails & Borum, 2003; Watson et al., 2010). Reasons for advocating for the voluntary nature of CIT include those who volunteer are motivated and service-oriented, it will produce the best outcomes and the true core value of CIT is not diluted because not all officers receive training (Cohen, 2023; Compton et al., 2017;

Watson et al., 2010). However, other law enforcement professionals and researchers argue that all police officers should receive CIT training and that this would allow for there to be more officers that are trained, therefore reducing the problem of not having enough CIT officers available when needed (Morabito et al., 2017). Furthermore, in one study, a CIT-trained captain stated that if all police officers received CIT training, CIT would be more successful (Canada et al., 2010). As noted above, those who have received training believe that it is not enough and they need more (Bonfine et al., 2014; Cohen, 2023; Vermette et al., 2005). In a series of semi-structured interviews with 57 law enforcement officers across multiple agencies in Texas, it was observed that while mental health training is more widely available than it ever has been, it is still not enough (Cohen, 2023). Furthermore, one police officer discussed how they receive a great deal of training, but there is still a lot they do not know when it comes to mental health (Cohen, 2023).

Research has shown that while law enforcement professionals have received training, some do not believe it to be adequate. It has also been observed that advancements in training are not the only area in which improvements can be made. For example, training is needed to improve police response to PwMI; however, if resources are not available in the community, the impact of training is weakened (Canada et al., 2010; Cohen, 2023; Cooper et al., 2004; Dupont & Cochran, 2000; Husted et al., 1995; Lamb et al., 2002; Steadman et al., 2001; Watson et al., 2011). For example, in one study, it was observed that the biggest barrier to the successful implementation of CIT was inadequate services in the community, with one police officer stating that they cannot do their job because there are no resources (Canada et al., 2010). A similar sentiment was stated by another police officer in a separate study who explained how the lack of

training is not where the issue lies, but rather the problem lies in the community where there is no corresponding mental health support (Cooper et al., 2004).

In their study, Lamb et al. (2002) discuss how neither the criminal justice system nor the mental health system can effectively manage mental health crises they may face in their community without support from each other. Similarly, Steadman et al. (2001) note that for programs to be successful, mutual respect between mental health professionals in the community and law enforcement is needed. Therefore, improving collaborations between both systems can be an effective tool to improve police encounters with PwMI. Ways in which this can be achieved include problem-solving meetings, ride-alongs, and in-service training involving both agencies (Husted et al., 1995). Overall, successful and adequate collaborations between the criminal justice system and the mental health system are needed in order to effectively respond to calls for service involving PwMI. It is very well having police officers trained, but if there are no resources available in the community, the impact of training is weakened.

Current Study

Existing research on police response to PwMI has looked at how stigma, use of force, and dispositional options can impact the ways in which police officers respond to calls for service involving PwMI. Similarly, research has examined the effectiveness of CIT in improving the ways in which police officers respond in their encounters. It has also been examined whether or not police officers, with or without training, feel prepared to respond and what changes could be made to improve encounters. Studies that have been discussed in this chapter tend to focus on law enforcement professionals in police departments in large cities and counties across the United States, and they often utilize quantitative data research methods, such as surveys. Few studies examine police response to PwMI in more rural areas (Yang et al., 2018), and so research

is needed to understand how police officers respond to individuals with mental illness in rural areas. It is reasonable to expect rural officers to respond differently than their urban counterparts for different reasons. Firstly, mental health training may look different for rural officers, and it may not be as widely available or utilized. Additionally, mental health services and resources may be scarce in rural areas compared to cities, thus affecting dispositional options for police officers and how they respond to those in a mental health crisis.

Furthermore, few studies have examined this topic using qualitative research methods (Cohen, 2023; Hanafi et al., 2008), therefore, more qualitative research is needed to understand this topic more and develop our knowledge further. In the study conducted by Hanafi et al. (2008), two prominent themes emerged when examining the impact of CIT; increased knowledge and awareness of mental illness, and practical application of skills learned. Through interviewing police officers, additional findings may emerge on the impact of CIT and this may differ for officers in rural areas. Furthermore, Hanafi et al. (2008) conclude by stating that additional research should investigate the differences between CIT-trained officers and non-CIT officers; therefore, this study aims to interview officers who have received training and officers who have not in order to add to the literature. Overall, the current study will add to the literature by using interviews to explore police response to PwMI in a rural location within the United States.

Chapter Summary

This chapter reviewed existing literature on police responses to PwMI and how training can improve responses. An overview of stigma, use of force, and dispositional options as elements of police response was discussed, as well as preparedness and what changes law enforcement professionals and researchers want to see happen. While a considerable amount of

research has been done on this topic, most of it has taken place in larger cities and counties across the United States; thus, there still is a gap in the literature on police response in rural areas. The following chapter will discuss the methodology used in the current study, focusing on the sample, data collection, and method of analysis.

Chapter 3. Methodology

Introduction

Chapter two examined existing literature on police response to individuals with mental illness and training to improve response. Most studies used quantitative methods and focused on police departments and training programs in large metropolitan cities or counties across the United States, with few using qualitative methods or examining police response and mental health training in rural areas. The aim of this study, therefore, is to fill this gap in the literature and explore the police response to individuals with mental illness in rural areas using qualitative methods. It is important to utilize qualitative methods as it will allow for a deeper understanding to be gained on the topic and the "why?" to be explored in greater depth. This chapter will discuss the methodological approach, including the sample size, data collection method, research questions, and data analysis.

Sample

The sample for this study included police officers from departments across East Tennessee. The researcher reached out to supervisors from a number of police departments in the region and discussed the aims and purpose of the study in order to be granted permission to interview officers in their departments. In addition, the researcher used two sampling techniques to obtain a sample. First, the research used a snowball sampling technique in which participants passed along the contact details of colleagues and fellow officers who could possibly participate in the study. Secondly, a purposive sampling technique was used in which the researcher used a webpage that contained the contact information (email address and/or telephone number) of every police chief in Tennessee. The researcher selected 15 police chiefs from the available list that were located in East Tennessee and that also had an email address provided. As a result of

the above-mentioned methods, the researcher obtained a sample of 19 participants. The sample included officers from seven police departments across East Tennessee.

The sample consisted mostly of males, with only three female participants. The ages of police officers ranged from 25 to 59 with an average officer age of 35.3 years. The average years of service was 9.5 years with the shortest being two and the longest being 32 years. Regarding education, the majority of police officers (n = 10) had a bachelor's degree, followed by those with a master's degree (n = 4). One police officer's highest level of education was a high school diploma, two police officers held an associate's degree, and one had completed some college. In addition, one police officer is working on their PhD. Furthermore, the study aimed to examine differences between officers who had CIT training and officers who did not. Therefore, the sample consisted of police eight officers who had CIT training and 11 who did not.

Data Collection

The researcher created an interview guide to answer three research questions (Table 2). Following this, the researcher conducted semi-structured interviews with police officers in order to examine police response to individuals with mental illness. The use of semi-structured interviews allowed for an in-depth collection of data that could not have been gathered from structured interviews or surveys. In addition, the aim of this study was to contribute to the qualitative literature on this topic, therefore, semi-structured interviews were necessary. Before the interview, participants were provided with an informed consent document which stated the aims of the research in addition to any potential benefits that could be gained from their involvement or any potential risks that could arise. All participants provided verbal consent to be interviewed and the majority of participants (n = 18) agreed to have their interviews recorded.

During the interviews, no information that could identify the participants was collected and the names of police departments that participated remained confidential. Following the interviews, the researcher transcribed all data, and the recordings were then deleted. During this process, the participants were also assigned names (e.g., Police Officer 1, Police Officer 2) in order to further the protection of their anonymity.

Table 2

Research Questions

RQ1:	Do police officers hold stigmatizing views and attitudes towards PwMI?
	RQ1a: Do officers report stigma associated with PwMI?
	RQ1b: Do officers report social distance associated with PwMI?
	RQ1c: Do officers who have received CIT training differ from those who have not on stigma or social distance.
RQ2:	Do police officers feel prepared and competent to handle calls for service involving PwMI?
	RQ2a: Do police officers feel prepared to handle calls for service involving PwMI?
	RQ2b: Do officers feel trained to distinguish between symptoms of mental illness?
	RQ2c: Do officers who have received CIT training differ from those who have not on issues related to preparedness and competency of handling calls involving PwMI?

(continued)

Table 2 (Continued)

	RQ2d: What challenges do officers face when making decisions on how to respond to a call involving PwMI?
	RQ2e: Do officers feel that there are sufficient options available for responding to calls for service involving PwMI?
	RQ2f: Are there any barriers that need to be addressed to improve the response to calls for service involving mental illness?
RQ3:	Do officers who have received CIT training perceive this training as adequate? In what ways is it adequate and in what ways is it not?
	RQ3a: Do officers perceive CIT training to be adequate in improving outcomes?
	RQ3b: Has there been any unintended outcomes associated with implementing CIT training?

Demographic Questions

The beginning of the interview comprised a series of questions relating to the individual characteristics of the police officer. In this section, police officers were asked questions about their age, highest level of education, and years of service. In addition, questions were asked about how frequently they respond to calls for service involving PwMI and how much of their workload is dedicated to such encounters. This allowed the researcher to receive an overview of the sample and also receive information on the participants' previous encounters with individuals with mental illness and set the tone for the rest of the interview. Furthermore, participants were

asked if they knew what their department's policies and procedures were regarding responding to calls for service involving PwMI.

Research Question #1

Stigma is an element that has been explored in a lot of research; therefore, the following section of the interview guide aimed to answer the first research question *(Do police officers hold stigmatizing views and attitudes towards PwMI?).* The researcher used open-ended questions in order to assess whether police officers held stigmatizing views towards individuals with mental illness. The first question aimed to understand how calls that involve PwMI differ from calls with individuals without mental illness. Participants were then asked if they were uncomfortable during encounters with PwMI and what their perceptions were of PwMI and levels of dangerousness. At the end of this section, participants were asked their thoughts on what caused mental illness. These questions aimed to gain an understanding of any stigma that police officers might hold when encountering PwMI, but in such a way as to be mindful of the sensitivity of the topic.

Research Question #2

In order to add to the literature on training and preparedness, the next section of the interview was comprised of questions designed to answer the second research question (*Do police officers feel prepared and competent to handle calls for service involving PwMI?)* The researcher asked the officers a series of questions in order to gain an understanding of whether police officers feel prepared to respond to calls for service involving PwMI. Follow-up questions were asked to assess why the officers felt prepared or not. Furthermore, the researcher asked specifically whether or not the officer had received CIT training. Depending on the answers given, the researcher asked a different set of questions. CIT-trained officers were asked about

their training, what it entailed, and how CIT, if at all, impacted their ability to respond to these types of calls. For officers who had not received CIT training, the researcher asked questions related to any mental health training they might have received and if they wanted to receive CIT training. The last questions of the interview guide related to barriers and challenges that officers face when responding to calls involving PwMI. In order to understand what barriers and challenges are present, the researcher used open-ended questions to answer this research question and the researcher followed with a question related to changes the officer would like to see implemented in order to address these barriers.

Research Question #3

The interview also consisted of a selection of questions in order to address the third research question *(Do officers who have received CIT training perceive the training as adequate?)* The researcher specifically asked CIT-trained officers whether or not they believe CIT training to be adequate when responding to calls for service involving PwMI. Furthermore, the researcher asked officers what unintended outcomes, either positive or negative, have been associated with the implementation of CIT. Lastly, the final question asked allowed the officers to elaborate on anything discussed throughout the interview or to add any additional comments.

Data Analysis

The researcher transcribed all interviews that took place and then performed a content analysis. In the analysis, the researcher examined each interview and identified recurring themes discussed by the police officers. The recurring themes allowed the researcher to answer the above-mentioned research questions using quotes from the officers, and examine any similarities or differences in answers between the officers.

Chapter Summary

This chapter discussed the methodology of the study, including the research questions, sample, data collection, and data analysis. The researcher contacted police departments in East Tennessee and successfully interviewed 19 police officers about their responses to individuals with mental illness. The interviews were semi-structured, enabling the researcher to ask a series of set questions while also allowing for follow-up questions to be asked when deemed suitable. The interview guide structure was discussed, along with questions that were asked in order to answer the research questions. Furthermore, the researcher conducted a content analysis on the interviews once they were completed and had been transcribed. The following chapter will discuss the findings of the study, with the final chapter discussing the limitations and implications of the study.

Chapter 4. Results

The purpose of the current study was to explore the response of police officers to calls for service involving PwMI. Chapters one and two introduced this topic and examined the existing literature on police response and training to improve response. The third chapter discussed the methodology of the current study, including sample size, data collection, the interview guide, and the method of analysis. This chapter will discuss the findings from the interviews. In order to answer the research questions that have been discussed previously and are reiterated below (see Table 3), a content analysis was performed. The following sections discuss the results of the findings associated with each research question.

Table 3

Research Questions

RQ1:	Do police officers hold stigmatizing views and attitudes towards PwMI?
	RQ1a: Do officers report stigma associated with PwMI?
	RQ1b: Do officers report social distance associated with PwMI?
	RQ1c: Do officers who have received CIT training differ from those who have not on stigma or social distance.
RQ2:	Do police officers feel prepared and competent to handle calls for service involving PwMI?
	RQ2a: Do police officers feel prepared to handle calls for service involving PwMI?
	RQ2b: Do officers feel trained to distinguish between symptoms of mental illness?

(continued)

Table 3 (Continued)

	RQ2c: Do officers who have received CIT training differ from those who have not on issues related to preparedness and competency of handling calls involving PwMI?
	RQ2d: What challenges do officers face when making decisions on how to respond to a call involving PwMI?
	RQ2e: Do officers feel that there are sufficient options available for responding to calls for service involving PwMI?
	RQ2f: Are there any barriers that need to be addressed to improve the response to calls for service involving mental illness?
RQ3:	Do officers who have received CIT training perceive this training as adequate? In what ways is it adequate and in what ways is it not?
	RQ3a: Do officers perceive CIT training to be adequate in improving outcomes?
	RQ3b: Has there been any unintended outcomes associated with implementing CIT training?

Introductory Questions

As discussed in Chapter 3, the sample included 19 police officers from seven police departments across East Tennessee. The sample was predominately male with only three female participants. The ages of police officers ranged from 25 to 59 with an average officer age of 35.3 years. The average years of service was 9.5 years and ranged from two years to 32 years. In addition, eight police officers had completed CIT and 11 officers had not.

Police officers were asked how frequently they responded to calls involving PwMI. The answers provided by the officers varied widely. Several officers (n = 8) indicated that these calls were handled daily with two officers stating that these calls comprised approximately 60 percent of all calls for service. In contrast, two officers (one CIT-trained and the other non-CIT-trained) indicated that they handled approximately two calls per month involving PwMI. Overall, there did not appear to be discernable differences between CIT and non-CIT officers with regards to the frequency of calls they respond to. Furthermore, officers were also asked whether they were aware if their police department had any specific policies or procedures in place regarding how to deal with calls involving PwMI. The majority (n = 14) said that there were policies and procedures in place, and these included sending CIT officers to respond first and taking the lead, requiring all officers in the department to be CIT trained, annual training, and pushing for de-escalation tactics. Three police officers stated that there were no policies or procedures in place in their department, whereas two officers did not know.

Research Question #1

Research Question 1 aimed to understand if police officers hold stigmatizing views towards PwMI and whether or not there is a difference in stigma among CIT-trained officers compared to non-CIT-trained officers. In order to see if police officers held stigmatizing views and attitudes, officers were asked if they felt uncomfortable during encounters with PwMI and what their perceptions were about PwMI and their levels of dangerousness.

The majority (n = 15) of officers said that they are not uncomfortable during encounters with PwMI. For example, one police officer stated, “You know, I've done probation, I've worked with the Department of Children's Services, so I feel like I've been around a lot of people that

have some form of mental illness. I'm a big proponent of getting comfortable with being uncomfortable... So, for me personally, it doesn't make me uncomfortable."

Two police officers said they felt uncomfortable but that their discomfort depended on certain factors. For example, one of the police officers said they felt uncomfortable depending on the mental illness, and the other officer said they were uncomfortable if they did not know what they had on them, such as weapons. Furthermore, one police officer did say they are uncomfortable during encounters with PwMI.

Whilst the majority (n = 15) of police officers stated they were not uncomfortable during encounters with people with mental illness, a different pattern emerged when police officers were asked about their perceptions of PwMI and their levels of dangerousness. For example, only three officers said that PwMI are not dangerous. Furthermore, two officers stated that they are more volatile. On the other hand, the majority (n = 9) of police officers said that people with mental illness could be more dangerous or have the potential to be more dangerous. Police Officer 15 stated, "I mean, potentially, they could be more dangerous, you know, like, being more mentally unstable. They're, you know, in a crisis state not thinking clearly, you know, may not be thinking of the best outcomes of their decisions and things like that." Furthermore, five police officers said that they have a heightened sense of danger when interacting with PwMI. Police Office 5, for example, stated:

> My danger awareness is going to spike because I'm going to be concerned that those are not always going to behave rationally. And whereas others you know, might be like, okay, I can maybe shoot this police officer and spend the rest of my life in prison or die for it, where somebody who suffers mental health crisis is not going to go through that logical

sequence in their mind. So definitely, when interacting with them, I have a more heightened sense of personal danger.

Similarly, Police Officer 10 also discussed their heightened sense of danger with being more on guard and stated, “On a scale of one to 10 I'll probably put it at a six or seven … You know when we respond to that, obviously the unknown is pretty big so I guess I usually tend to be more on guard and a little more of a stress level just because of the unknown of going into these calls.”

To further see if police officers held stigmatizing views towards PwMI, police officers were asked how calls involving PwMI differed from calls involving individuals without mental illness. Five officers stated that calls involving PwMI can be more unstable or more unpredictable. Police Officer 15 discussed levels of unpredictability during calls and stated, “I think those would be a greater level of unpredictability you know, mental illness, or mental crisis look different for every person. So, you don't know what you're walking into.” Similarly, one police officer said that these calls tend to be more hectic.

Four police officers stated that they go into calls exactly the same and treat them the same regardless of the mental illness. Police Officer 14 stated, “We don't answer calls differently because somebody is mentally ill. We enter a call safely no matter what ... So sometimes the best course of action is making sure they're safe and taking them to a safe place, which sometimes ends up being the jail.” On the other hand, three police officers said that they go into calls differently if they know they are dealing with someone with a mental illness. Police Officer 5 stated, “It’s going to be different because a lot of times their mental capabilities at the time are going to be different. So, you have to approach that different versus somebody who's maybe able to be reasonable and logical, if that makes sense ... And so you just you just have to take a different approach.”

As discussed above, Research Question 1 also sought to understand whether or not officers who have received CIT training differ from those who have not on stigmatizing beliefs and attitudes. Regarding discomfort, the majority (n = 6) of CIT-trained officers said they are not uncomfortable, one officer stated they are uncomfortable, and one felt uncomfortable if they didn't know what they had on them. With regard to dangerousness, over half of CIT-trained officers (n = 5) said that PwMI can be more dangerous, two officers stated they are unpredictable, and one officer said that they have a heightened sense of danger. Similar themes emerged from non-CIT-trained officers. The majority (n = 8) of officers stated they were not uncomfortable during encounters with PwMI and two officers stated that they are uncomfortable depending on the mental illness that the individual has. Regarding dangerousness, two non-CIT-trained police officers stated that PwMI are not dangerous. Five non-CIT-trained officers reported a heightened sense of danger when responding to calls involving PwMI, and four officers stated that PwMI can be more dangerous depending on their mental illness or they have the potential to be more dangerous. Similarly, one police officer said that PwMI can be more unpredictable. Overall, CIT-trained officers had similar levels of comfort compared to non-CIT-trained officers when interacting with PwMI.

Research Question #2

Research Question 2 sought to answer whether police officers felt prepared to handle calls for service involving PwMI and whether levels of preparedness differed among CIT-trained officers and non-CIT-trained officers. Furthermore, Research Question 2 also sought to understand the challenges that police officers face when dealing with PwMI and what options are available to them as well as improvements they want to see in order to overcome these barriers. The vast majority of police officers said that they felt prepared (n = 15) or mostly prepared (n =

3) to handle these calls. One police officer said they felt prepared in some ways due to the training that they had but did not feel prepared in other ways because of the support and resources in place. Furthermore, more non-CIT-trained officers (90.1%) felt completely prepared compared to CIT-trained officers (62.5%). Police Officer 2 stated:

> Honestly, it's a yes and no type of thing. It's easy for me to say yes, because of the CIT training and I know what to look for and probably a place where they need to be taken to … because there's been times where I've dealt with a person and they go to a hospital … and two days later, I'm dealing with them in that same state the next day. I think police needs a little bit more support, there needs to be more communication or more, I guess, transparency with the mental health institutions we have in this area because a lot of us get frustrated because we'll say someone that needs to get help or get an advocate. And two days later, we'll be out with them in the same situation and it's just a never-ending cycle ...but when it comes to the interaction itself, and how to talk to them and de-escalate them, I feel prepared for that.

Overall, police officers felt prepared to handle calls for service involving PwMI. However, the reasons why they felt prepared differed. The most common answer given by police officers (n = 8) for why they felt prepared was their experience. For example, Police Officer 4 stated, "… it's something that's become so common. I mean, it's a majority of what this job has become. So, I don't have any problems with that. … we've had a lot of like, personal experience with it." Four non-CIT-trained officers and one CIT-trained officer said that their general training through the academy and police department makes them feel prepared. Three CIT-trained officers said that CIT training was the reason for their levels of preparedness. Other

reasons officers felt prepared included, education (n = 2), their personality and ability to talk to people (n = 2), and supervising officers that trained them well (n = 1).

To further understand police officers' levels of preparedness, participants were asked whether they felt trained to recognize mental illness and distinguish between symptoms of mental illness. Almost every police officer (n = 17) felt that they could recognize mental illness and distinguish between symptoms of mental illness. For example, Police Officer 1 stated, "Yeah, definitely. I can. I'm pretty good at spotting that out now." Similarly, Police Officer 7 said, "Yes, I would say yeah, I mean, you could definitely kind of tell it, you can definitely tell someone that's a medical crisis as opposed to somebody who's you know, say under the influence a narcotic or something." This was the most common answer given by the police officers regardless of whether they had CIT training or not.

One police officer, who was CIT-trained, hoped that they could, but did not say that they definitely could. Furthermore, one police officer said they did not feel trained to recognize mental illness and distinguish between symptoms of mental illness due to the difficulty of distinguishing between mental illness and drug-induced episodes. Police Officer 3 stated, "It makes it incredibly difficult to distinguish what is a mental illness versus what is a drug-induced episode of schizophrenia or excited delirium, or some other drug-induced state of mind … If I'm being honest with myself, it's probably a no because my mind always goes to drugs."

Furthermore, the CIT-trained police officers in this study were also asked questions to understand if they felt more prepared than their colleagues. Most (n = 5) of the CIT-trained officers felt more prepared than their colleagues and the reason for this varied, with one officer stating that they felt more prepared because, during their CIT training, they were provided with a binder of resources which non-CIT officers do not have. In addition, this police officer said, that

in an ideal world and if the department had the manpower, only CIT-trained officers should respond to these calls. Another officer said they have more awareness than those who have not had the training. One officer's police department was completely CIT-trained so they could not say that they felt more prepared than their colleagues. However, two CIT-trained officers said that they do not feel more prepared than their non-CIT-trained colleagues, with one officer stating, "If I did feel more prepared, it doesn't have anything to do with the CIT training."

The final set of questions asked aimed to understand what challenges officers face when responding to calls involving PwMI, whether there are sufficient options available to them to successfully resolve these calls and any barriers that need to be addressed in order to improve these challenges and the response to calls for service involving PwMI. When answering the question about challenges, several different answers were given with some officers providing numerous challenges that they experience. The most common (n = 7) challenge that officers face when responding to calls involving PwMI is a lack of resources, facilities, and readily available resources. Police Officer 4 discussed the lack of resources and stated, "The only barrier I could think of that would be like a regional thing is, like I said, the lack of inpatient facilities. You know, the thing that I've always heard is like during Reagan's administration in the 80s, all the mental health care facilities were shut down to save cost." Similar sentiments were echoed by Police Office 11 who stated, "I think I think some of the biggest issues with it are readily available resources. You know, there's only a certain number of places that we can take someone or guide someone to go in at three o'clock in the morning. It's not the most opportune time to figure out which of those resources are available."

Following the lack of resources, the next most common challenges reported by police officers (n = 4) included dealing with family members and members of the public, cooperation,

and not saying “the magic words.” Magic words refers to individuals stating that they are a danger to themselves or others. If an individual states these “magic words,” they can be involuntarily committed under Tennessee law. Police Officer 4 discussed the difficulty in dealing with members of the public and stated:

> The not understanding that I can't just load them up and take them to the hospital. Because we will get calls about people you know, sitting on park benches, talking to themselves, obviously mentally ill, you know … doing all sorts of unusual activity … The public calls us for this because they obviously want us to get them help. And then I show up and I'll ask him, do you want to go to the hospital and they're like, no. Do you want to kill somebody or yourself? No. And all they're doing is sitting there and talking to themselves and doing unusual behavior. And that's all I can do … And then I leave and the public sitting there scratching their head, saying this person obviously needs help. Why didn't you help them? And there's nothing I can do.

Police Officer 12 discussed the challenges of the “magic words” and the challenge of dealing with family members:

> You know, somehow the biggest challenge would be those that you can't convince to go to the hospital when they really need to go to the hospital. And they're not saying the magic words to get into the hospital. Those are the biggest challenges … That’s the frustrating part, especially when you're dealing with family members because they think that we can just make them go to the hospital. And they get very upset with us for like, I know, you see what you're seeing. I'm seeing what I'm seeing and I think they need to go to the hospital. They don't want to go to the hospital. So, I can't make them.

Police Officer 6 also discussed the challenge of the "magic words" and said, "Unless they say the magic words of I want to harm myself someone else then I then I can't force something and then it's probably going to be a continual not issue but continual call out for the rest of the day, or the rest of the week, cuz we can't force them to get help unless they say the magic phrase."

Other challenges that police officers reported include medical staff (n = 2), communication (n = 2), unpredictability (n = 1), weapons (n = 1), and peers getting in the way (n = 1). For example, Police Officer 2 discussed the challenges of fellow officers responding and how they can escalate situations:

> I think the only challenges that you face is just your peers. Mainly because a lot of the officers I work with don't have that school. So, you know, you can't time it perfectly sometimes. So, the officer will get there before me and they're already talking to the person and you're just praying to God that they're not escalating it more … some of them are just ignorant on how to respond. So, some of the challenges I face is just trying to beat officers there so that I can kind of get it under control as quickly as possible so none of us get hurt.

Lastly, two police officers stated they did not face any challenges when dealing with calls for service involving PwMI.

The police officers in this study were also asked questions in order to understand if police officers feel that there are sufficient options available for responding to calls for service involving PwMI. The majority (n = 8) of police officers said that there are somewhat sufficient options available to them. Officers 4 and 7 stated how they are able to resolve issues once but there are no long-term resolutions and they deal with the same people again. For example, when asked if there are sufficient options available Officer 4 stated, "No, no, no, not long term. I can

fix the problem for an evening. Yeah, that's it. It is a helpless, helpless feeling." Similarly, Officer 7 said, "To a point, because it seems like sometimes we take somebody somewhere, and they end up going there. And we still have to end up dealing with that same issue with the same person at a later date."

Officers 13 and 5 discussed the limited facilities available to them. Officer 13 stated, "There's not always availability or vacancies to provide those options to people who need them. They're always full. Yeah, the resources are there, but they're not necessarily available." Similarly, Officer 5 said:

> In our city, there is because we do have mental health facilities that we can try to get them to, and try to encourage them to go to so our surroundings? Yes, I would say that there are but we're limited and I think we could have more of more. Okay, they're pretty they're pretty full… So, we have options, but I think it would be nice if we had more options because they stay pretty full.

Five police officers believed that there are sufficient options available to them. One police officer who believed there are sufficient options discussed how they can take individuals suffering from mental illness to a hospital and they can go to a mental health facility:

> So, we typically … bring them to the regional hospital, they are put in a safe room there … they come in and evaluate and assist them with what they're needing and that's to go to a mental health friendly facility for further treatment, and they would do that. Or if it's something that can be handled there. They would do it that way to prevent them from having to go somewhere for the 72 hours or whatever the case may be … That's a way of getting them safe and other people safe, you know, secured and unarmed and things like

> that out of their opportunity of having a way of doing something to themselves or others. Think in terms of defusing a situation on scene.

Officer 17 also discussed the resources that are available to them and stated:

> Oh, yeah, I mean, I think they're developing as the years go by, there's more than what I started with, you know what I mean? It's kind of like, I used to say I'm sorry for your luck, man, or whatever the case is, you know, I'm not a doctor, I can't help you and we can't take you to the hospital or whatever the case is used to be like that. But now as the times are developing, I feel like people are becoming more prepared and more equipped to handle the certain types of circumstances. There's definitely more resources out there now than when I started.

Lastly, six police officers said there aren't sufficient options available to them. Police Officer 19, for example, discussed the issue of insufficient resources and stated, "There are insufficient resources up front but not sufficient long term for the individual …So it's a revolving door." Similar sentiments were echoed by Police Officer 9 who stated, "No, we don't have tremendously great options. If we got someone who's crazy, and they're not making suicidal threats or homicidal threats, there's not much we can do. So, we have to let them be. And it's sad because we just leave someone who's crazy on the street. It's not the best option, but you know, even crazy people have rights." Furthermore, Police Officer 14 discussed a lack of facilities and a lack of funds when asked if there are sufficient options available and said, "I'm gonna say no to that … if those options are full, there's just not anywhere to take them unless somebody is going to be responsible … The problem is we don't have you know the funds or the facilities to take care of them."

The final question that police officers were asked in order to answer the research question related to barriers that need to be addressed in order to improve response to calls for service involving people with mental illness. Officers identified two primary barriers that need to be addressed. The first barrier is related to training (n = 6) and the second barrier that needs to be addressed is more long-term facilities and services (n = 6). Out of the six officers that discussed training, only two were CIT-trained. The officers that mentioned improving training as a way to address barriers stated that there to be more in-person training, more in-depth CIT, or to have everyone CIT trained. For example, Officer 1 said:

> You know, I think if you took more of an emphasis on, you know, mental evaluation, or mental training, during those times, instead of just like doing online, which is the most oh my god, I hate it. I hate online training. I don't care. And I hate them. They're so useless. So, I think if they put more of an emphasis on it in person, and did it that way, I think that'd be more beneficial.

Similarly, Officer 6 discussed improving CIT training and stated:

> I think if they offered another level of CIT training, I think it would be helpful because there are they're always discovering or adding on to like new mental illnesses. And there's always a different way to react to different ones. If they did continual training or an updated version or just like a crisis intervention team, to training would be very beneficial.

As mentioned above, in addition to training, the most common barrier that officers wanted to address was long-term facilities and services. Officer 16 discussed the need for long-term treatment:

> I would say like the biggest one is the long-term treatment, you know? Yeah, because ultimately, if we fix the solution on scene, we get them to the hospital, and obviously, they're like, man, here's your medicine, see you later have a good day. You know, that's not fixing anything, and we're going to do a second break again because they're not going to be taking their medicine or whatever the case is out. So, I think if there was more long-term treatment, more, essentially more … you know, trying to fix the behavior or whatever the case is … So, that being said, I think that's, that's my major point is, is if you were to fix the long term solution of the people that we deal with day to day, I think that's going to be that is going to eliminate the revolving door.

Surprisingly, four police officers were unsure of what needs to be addressed in order to improve response with one officer stating. Furthermore, three police officers want there to be somebody who is trained in this field to accompany officers on every shift or for there to be a mental health service provider available. For example, Police Officer 3 stated, “I want somebody who is trained in this working on my shift with me every time I'm on shift. Something like this comes up. I don't have to wait I don't have to you no wonder what I'm going to I have somebody there that has the answers.”

To further improve response, two police officers want there to be better collaborations between law enforcement and medical facilities and staff and for there to be greater cohesiveness. Police Officer 7 discussed cohesiveness and said, “I would like to see I would say like more cohesiveness working together between, say law enforcement and like the medical side of things, not necessarily to the point to where they need to violate HIPAA, or anything like that. But as far as helping get people to and getting them the help that they need.” Similarly, Police

Officer 2 discussed having a liaison between police departments and mental health facilities and having everyone working together in order to improve barriers. They stated:

> I think the best improvement would be to have an officer that is a liaison between the police department and these mental health institutions. I think a lot of officers feel like the mental health institutions are, it's like playing Hot Potato like we'll take them there and then they'll bounce them back out. And they get very frustrated and I don't understand why. I think having a liaison between us and them would not only keep the peace to where like we can use them and you know, they can be helpful to us and try to get them the help they need but I think they would also hold some accountability… So, it needs to be everybody working together as a whole.

Research Question #3

The final research questions sought to understand whether or not officers perceive CIT training to be adequate in improving outcomes and whether there have been any unintended outcomes associated with implementing CIT training. The majority of CIT-trained officers (n = 6) perceived CIT training to be adequate. The reasons for this varied among officers. One police officer, for example, discussed how the training covered lots of topics and involved roleplaying which was beneficial:

> I think it was very good training. It went over a lot of topics to understand what we're dealing with. And then the hands-on training as much as I hate doing the roleplay scenarios that help this was it's better to do it and roleplay and mess up and learn what you did in real life mess up and then you got to deal with that.

In addition, Police Officer 16 discussed that the individual leading the CIT training genuinely cared about the training and believed it was above standard. They stated:

> I mean, you could go into a class and teach it and not really care about it. I mean, the lady genuinely cares about the performance and like trying to get these people to receive help … it's something that she's passionate about, you know, not everybody might be passionate about it. But at the same time, if you're passionate about something that you're teaching, you're gonna give it more … I feel like and I don't know if she does this in every class, but she did it in our class and she kind of, you know, took her time with it, explained it and, you know, to a bunch of cops you know, I mean, that's kind of hard to do … I think that it was a great course. I think it was above standard.

One police officer said that CIT training was somewhat adequate with the reason being there are good resources provided but life experiences help more than CIT. They said, "There is no amount of classroom that is going to prepare you adequately to deal with that situation face to face." Lastly, there was just one police officer who did not perceive CIT training to be adequate. This police officer stated that the training was not done correctly, and they believed they did not learn any new skills and they are already doing these skills. Furthermore, this police officer felt as though the staff were judgmental and that they were being told they didn't know what they were doing. For example, they stated, "I didn't feel like I really learned any new skills from it. I think I was already doing it."

The final question that police officers were asked in order to answer the research question related to whether there have been any unintended outcomes associated with the implementation of CIT training. The majority of CIT-trained officers (n = 6) believed there were unintended outcomes associated with the implementation of CIT training. However, two officers did not think there were any unintended outcomes.

For the police officers who did believe there to be unintended outcomes, their answers varied. One police officer, for example, discussed how CIT has resulted in them not having to constantly respond to the same people over and over again. They stated, "…we're able to call someone and say, hey, this person is saying this, this and this, and they're doing this because… You know, that opened up a lot more doors to where we're not having to constantly respond to that individual. We were able to just kind of get them on the path that needed to go." In addition, one police officer discussed that CIT has resulted in a higher expectation from the public of what can and can't be done. Police Officer 5 said:

> I think sometimes when we do this, I do think that the public in general has a higher expectation of what we're capable of doing. They think that they can't understand where we maybe we had to shoot somebody or someone… we're not specifically trained into identifying certain type of conditions or something. And so, I think sometimes the public has a higher perception of what they think that we can and can't do in the field when interacting with individuals in the middle of a crisis … I think the general public thinks, Oh, if we just give them more mental health training, they will never hurt anybody and that's not true.

Police Officer 13 discussed de-escalation techniques as an unintended consequence of CIT training. They stated, "…assumption that comes from CIT that people can be talked down to but that's not an accurate portrayal. De-escalation tactics don't work for everyone. I would assume that the implementation and the unrealistic ideals behind CIT have caused some officers to get hurt, and even worse, killed." Furthermore, Officer 15 stated, "They think that because we are dealing with someone in the middle of a mental health crisis we don't have to have as much officer safety… people think that but that is not really the case." Lastly, one police officer stated

that the loss of life is an unintended outcome, with another police officer stating that you can go through all the work and follow CIT training but individuals with mental illness still get released without the help they require.

Chapter Summary

This chapter discussed the content of the interviews with police officers and their responses to calls for service involving PwMI. Stigmatizing views and beliefs that officers may hold were discussed along with levels of preparedness between CIT-trained officers and non-CIT officers. In addition, the challenges and barriers encountered in their interactions with PwMI were explored as well as what improvements they wish to see. Furthermore, the opinion of CIT training and its implementation were discussed by CIT-trained officers. The final chapter will provide a discussion of these findings as well as address the limitations of the study, implications associated with the results, and directions for future research.

Chapter 5. Discussion

Police officer response to individuals suffering with mental illness has been widely studied, but most research has focused on police departments in metropolitan cities or counties with few studies examining how police officers respond in rural areas (Yang et al., 2018). Similarly, few studies have examined this topic using qualitative research methods (Cohen, 2023; Hanafi et al., 2008). This study sought to fill this gap in research by using qualitative research to further understand police officer response to individuals suffering with mental illness in rural areas. Semi-structured interviews were conducted with police officers across East Tennessee in order to answer three research questions. This chapter will discuss the results and their relation to existing literature. Furthermore, this chapter will address the implications and limitations of the current study as well as suggestions for future research.

Findings

Research Question #1

Research Question 1 sought to understand whether police officers hold stigmatizing views towards individuals with mental illness. Prior research on stigma has found mixed results among police officers and their attitudes towards PwMI. For example, research has found that police officers view PwMI as dangerous and that they are less likely to help individuals who have a mental illness. However, research has also found that police officers view PwMI as more worthy of help and officers' responses are not affected when they receive information about an individual's mental illness (Ruiz & Miller, 2004; Watson et al., 2004a; Watson et al., 2004b). The results of this study show that the vast majority of officers are not uncomfortable during encounters with PwMI with one officer stating that they are uncomfortable. However, with regards to dangerousness, the majority of police officers stated that PwMI could be more

dangerous or have the potential to be dangerous, with only three officers stating that PwMI are not dangerous. The results of the current study are consistent with previous research that has found that police officers differ in their attitudes towards PwMI and that some officers hold stigmatizing views while other officers do not.

Research Question 1 also examined whether police officers who have received CIT training have different levels of stigma compared to those who have not received CIT training. Findings from the current study were consistent with previous research which has found that while CIT is an effective tool to reduce stigma among police officers in some studies, other research has found CIT training to not produce significant changes in officer attitudes (Bahora et al., 2008; Demir et al., 2009; Haigh et al., 2020). The results of this study showed that the majority of CIT-trained officers are not uncomfortable during encounters with PwMI, but one officer, despite their CIT training feels uncomfortable in encounters. Furthermore, over half of the CIT-trained officers believed PwMI can be more dangerous with some officers stating that PwMI are unpredictable. In addition, there did not appear to be a substantial difference between CIT-trained officers and non-CIT-trained officers with regard to level of stigma towards PwMI. The majority of non-CIT-trained officers also reported that they were not uncomfortable during encounters with PwMI and several CIT-trained officers believe that PwMI have the potential to be more dangerous or report a heightened sense of danger during these encounters. Overall, CIT-trained officers had similar levels of comfort compared to non-CIT-trained officers when interacting with PwMI and this finding was expected given the mixed results from previous research.

Research Question #2

The second research question explored preparedness and competency among police officers during encounters with PwMI as well as any challenges and barriers that officers might face when responding to these calls. Findings indicate that all officers, regardless of their CIT training status, feel prepared and competent or at least somewhat prepared to handle these calls. In addition, the vast majority of officers felt trained to distinguish between symptoms of mental illness despite their training status. Furthermore, this research question sought to examine the difference in feelings of preparedness between CIT and non-CIT-trained officers. Findings from this study indicate that more non-CIT-trained officers (90.1%) felt completely prepared compared to CIT-trained officers (62.5%). The findings from this study are inconsistent with previous research that has found that officers were more likely to report feelings of unpreparedness before CIT training and greater feelings of preparedness following CIT training (Ritter et al., 2010). This research is inconsistent with the findings from this study because all police officers, regardless of their CIT training felt prepared. Furthermore, more non-CIT-trained officers felt completely prepared compared to CIT-trained officers therefore suggesting that CIT does not impact levels of preparedness in the same way that other research has found.

Previous research has also examined the difference in preparedness between CIT and non-CIT-trained officers and has found that most CIT-trained officers believe that non-CIT-trained officers are not prepared to handle these types of calls (Bonfine et al., 2014). The results of the current study are consistent with the previous findings related to how CIT officers perceive their non-CIT-trained colleagues. Most of the CIT-trained officers stated that they felt more prepared than their colleagues whereas two CIT-trained officers stated that they did not feel more prepared than their non-CIT-trained colleagues. A possible explanation for why there is no

difference among officers in their ability to distinguish between symptoms of mental illness and why CIT does not appear to impact levels of preparedness in the same way that other research has found could be because of experience. When asked why officers felt prepared to handle calls and why they felt trained to distinguish between symptoms of mental illness, the majority of police officers said it was because of experience. Therefore, due to the high volume of encounters with PwMI, noted in the previous chapter, it could be assumed that this experience has been more beneficial in feelings or preparedness than training.

Research Question 2 also sought to further the understanding of any challenges that officers face when encountering PwMI, if there are sufficient options available to them, and what barriers need to be addressed to improve encounters. The most commonly reported challenge reported by police officers in this study was a lack of resources, facilities, and readily available resources. This result is not surprising, as prior research has shown that the biggest barriers experienced include inadequate services in the community, with officers stating that they cannot do their job because there are no resources (Canada et al., 2010). Furthermore, existing research has found that the problems lie in the community where there is no corresponding mental health support (Cooper et al., 2004).

Following the lack of resources, the next most common challenge reported by officers in this study was not saying "the magic words." Magic words refer to individuals stating that they are a danger to themselves or others. If an individual states these "magic words," they can be involuntarily committed under Tennessee law. Two out of the four police officers who discussed this challenge were from the same department and the remaining officers were from different departments. This finding was particularly interesting given that this was the second most common challenge reported by officers and that two officers explicitly used the words, "magic

words" and "magic phrase," therefore suggesting that this might be a common phrase used among police officers.

Prior research has indicated that police officers are not satisfied with the disposition options available to them (Wells & Schafer, 2006), and other research has indicated that only half of police officers are satisfied (Yang et al., 2018). These mixed findings are consistent with the findings from this study in which the majority of police officers said that there are somewhat sufficient options available to them, whereas five police officers believed that there are sufficient options available, and six police officers said that there aren't. While these findings are mixed, the majority of police officers believe that there are no sufficient options or somewhat sufficient options. This, therefore, suggests that overall, the options available to police officers need to be improved in order to allow for there to be more options or better options available.

Results from this study found that officers identified two primary barriers that need to be addressed. The first barrier is related to training, and the second barrier involves more long-term facilities and services. Officers in this study mentioned improving training as a way to address barriers and stated that more in-person training, more in-depth training, or having everyone CIT trained are ways to improve encounters and outcomes. Such findings are in line with previous research where officers stated everyone should be CIT-trained to improve outcomes (Canada et al., 2010). Additionally, previous research has observed that while mental health training is more widely available than it ever has been, it is still not enough (Cohen, 2023). Furthermore, officers in this study mentioned how long-term mental health facilities and services need to be available in order to improve responses and outcomes. This finding was consistent with previous research that has observed the importance of resources in the community in addition to training (Canada

et al., 2010; Cohen, 2023; Cooper et al., 2004; Dupont & Cochran, 2000; Husted et al., 1995; Lamb et al., 2002; Steadman et al., 2001; Watson et al., 2011).

In addition, two police officers stated that in order to address barriers and improve response there need to be better collaborations between law enforcement and medical facilities and staff as well as greater cohesiveness. The findings here support the literature that states that mutual respect between mental health professionals in the community and law enforcement is needed and that improving collaborations between both systems can improve police encounters with PwMI (Steadman et al., 2001).

Research Question #3

The final research question sought to understand whether officers who have received CIT training perceive this training to be adequate and whether or not there have been unintended outcomes associated with implementing CIT training. The majority of CIT-trained officers perceived the training to be adequate and stated that the training provided them with helpful resources and that the individuals responsible for delivering the CIT training were passionate. While the majority of CIT-trained officers perceived the training to be adequate, one police officer stated it was somewhat adequate and that CIT training provided good resources but life experiences help more. Furthermore, another officer believed that CIT was not adequate due to the training not being done correctly and they did not learn anything new. The current research does not entirely support the literature which has found that officers who have received training believe that it is important but it is not enough and they want more training overall (Bonfine et al., 2014; Cohen, 2023; Vermette et al., 2005).

The majority of police officers in the study believed that there were unintended outcomes associated with the implementation of CIT training whilst two officers did not think that there

were any unintended outcomes. Whilst the majority of officers believed there were unintended outcomes, the reasons for this differed among the officers. Officers stated that CIT has resulted in them not having to always respond to the same people all the time, and it has resulted in higher expectations from the public. Furthermore, officers stated that de-escalation techniques don't always work, officer safety is still paramount, loss of life is an unintended outcome, and despite going through CIT training PwMI still get released without the help they need. Overall, when examining perceived unintended outcomes of CIT, there was a difference among police officers in the answers they provided.

Overall, some support for CIT training has been expressed by officers, especially by those who are not CIT trained. Therefore, it appears that there is a perceived need for CIT training, and that the CIT-trained officers mostly perceive the training as adequate, but the differences between CIT and non-CIT-trained officers are not that large. It raises the question of whether or not CIT should be more widely implemented. Officers want there to be more training and they expressed a desire to be CIT trained, however, officers do not significantly differ in their levels of preparedness and almost every officer feels trained to distinguish between symptoms of mental illness regardless of their training status.

Implications

The results of this study increase our understanding of how police officers respond to individuals suffering from mental illness in rural areas. The majority of prior research has explored police response to PwMI in metropolitan cities and has utilized quantitative research methods. This study, on the other hand, provided an understanding of how police officers respond to PwMI in rural areas using qualitative methods. Findings from this study indicate that police officers are not uncomfortable during encounters with PwMI, but they perceive PwMI to

potentially be more dangerous. Therefore, stigma and attitudes towards PwMI are mixed. Given the mixed findings surrounding beliefs towards PwMI, a greater emphasis on reducing these stigmatizing views in training sessions would benefit police officers.

Furthermore, the results of this study provided an understanding of officers' levels of preparedness, the challenges they face when encountering PwMI, and what improvements they want to see to address barriers. Findings show that police officers feel prepared regardless of their CIT training status. In addition, the biggest challenge reported by police officers was a lack of resources and facilities. Similarly, the two primary barriers that they want to see addressed relate to training and more long-term facilities and services. These findings indicate that in order to improve how police officers respond to PwMI, there should be greater levels of mental health training and officers would benefit from this. Furthermore, in order to improve response, more long-term mental health facilities and services in the community should be implemented

Limitations

As with all studies, there are some potential limitations. Firstly, a limitation of this study is generalizability. While this study aims to contribute to this area of research by focusing specifically on rural areas, a sample size of 19 police officers is likely to limit the generalizability of the findings. The generalizability is limited in both the area itself, as this study interviewed police officers in East Tennessee, and even within this geographic area. In addition, this study was carried out by a single researcher; therefore, in the thematic analysis of the interviews, some of the data may have been misinterpreted by the researcher, or they may have overlooked other important details. Furthermore, this research assessed whether police officers hold stigmatizing views; therefore, some officers may not have answered truthfully in an attempt to hide their true beliefs. As such, this may impact the validity of the study. Lastly, in this study,

the researcher utilized a purposive sampling technique in which 15 police chiefs were selected and emailed from a list that contained the contact information (email address and/or telephone number) of every police chief in Tennessee. The researcher selected police chiefs in East Tennessee whose email address was provided. Therefore, as a result of this purposive sampling technique, police chiefs located in East Tennessee for whom an email address was not provided were not emailed. Overall, this sampling technique could affect the representativeness of the sample.

Future Research

This study aimed to examine police response to individuals suffering from mental illness, particularly in rural areas. While this study does further our understanding of this topic, other areas could be built on for future research. One area that could be explored further is the differences between male and female police officers and their response to PwMI. In this current study, there were only three female officers and all were CIT-trained. It would be beneficial to examine in greater depth if there are gender differences between men and women and their response to PwMI. Furthermore, while all female participants in this study were CIT-trained, exploring a larger sample of female police officers would allow us to determine if women are more likely to undertake CIT training and if so, what their motivations might be.

While this study examined police response to PwMI in a rural area, this study only focused on one region across the United States. Little research has been conducted in rural areas, therefore, future research could further our understanding by focusing on more rural areas across the country in order to examine what patterns emerge with regard to responding to calls involving PwMI.

Conclusion

Mental illness is prevalent across the United States and the pervasiveness can be seen across numerous areas of the criminal justice system, particularly with how police officers are often the first responders to calls for service involving those with mental illness. Previous research has examined how police officers respond to calls involving PwMI, how CIT can impact officers' response, how prepared police officers feel to handle these calls, and changes officers wish to see implemented in order to improve response. The previous literature has focused primarily on police officers in metropolitan cities or counties, therefore, the current study sought to fill this gap by exploring how police officers respond to individuals suffering with mental illness in rural areas. The results from these interviews provided knowledge on police officers' encounters with PwMI, including their levels of preparedness, challenges they face, barriers they want to see addressed, as well as the impact of CIT training. Furthermore, this study allowed for a foundation for future research to build upon and provided information on how police response to individuals suffering from mental illness can be improved.

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APPENDIX: Interview Guide

1) I would like to begin by asking a few demographic questions about yourself and your position and some introductory questions regarding your experience responding to calls with PwMI:
    a) Gender:
    b) How old are you?
    c) How many years have you been a police officer?
    d) What is your educational background? (highest level of education)
    e) On average, and to the best of your knowledge, how frequently do you respond to calls involving PwMI?
        i) How much of your workload is dedicated to these encounters compared to other duties?
    f) Do you know if your department has specific policies or procedures in place regarding responding to calls involving PwMI?
        i) If yes, please explain what these are.

2) I'd now like to ask some questions about your perceptions of mental illness and PwMI
    a) How do calls that involve PwMI differ from calls with individuals without mental illness?
    b) Are you uncomfortable during encounters with PwMI?
        i) If yes, what about these interactions make you uncomfortable?
    c) What is your perception of people with mental illness and levels of dangerousness?
    d) In your opinion, what causes mental illness?

3) I'd now like to ask some questions regarding feelings of preparedness to handle calls involving PwMI:
    a) Do you feel prepared/competent to respond to calls involving PwMI?
        i) If yes, why do you feel prepared and in what ways do you feel prepared?
        ii) If no, why do you not feel prepared and in what ways do you not feel prepared?

4) I would now like to ask you some questions regarding mental health training:
    a) Have you received CIT training?
        i) If yes:
            (1) Briefly, what did the training entail?
            (2) What was your motivation for undertaking CIT training?
            (3) Since undertaking CIT training, have you received any additional training related to mental health? If yes, please elaborate.
            (4) Do you think CIT has helped you in your encounters with PwMI and responding to these calls? Why or why not?
            (5) Do you believe CIT training is adequate? Why or why not?
            (6) Has there been any unintended outcomes associated with implementing CIT training?
            (7) Do you think CIT training has impacted your level of preparedness to respond to calls involving PwMI?
            (8) Do you feel trained to recognize mental illness and distinguish between symptoms of mental illness?
            (9) Do you think that you are more prepared compared to your colleagues or other officers who have not received CIT training? If so, how? If not, why not?
            (10) Do you think that only CIT trained officers should respond to such calls?

        ii) If no:
            (1) Have you received any mental health training at all? If yes, please elaborate on what this was.
            (2) Would you like to be CIT trained? Why or why not?
            (3) Do you think you are able to recognize mental illness and distinguish between symptoms of mental illness?
            (4) Do you think CIT training would impact how prepared you felt to respond?
            (5) Who do you think is more prepared to handle such calls. Why?

5) The final set of questions will relate to resolving encounters and decisions you are required to make:
    a) When deciding how to respond to a call involving PwMI, are there any challenges that you face?
    b) In trying to resolve these encounters, are there sufficient options available to successfully resolve issues?
    c) What barriers, if any, prevent you from successfully responding to/resolving encounters with PwMI.
    d) What improvements/changes, if any, would you like to see implemented in order to address barriers/to improve encounters with PwMI?

6) Before we go, is there anything else you would like to add?

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